NOTICE OF INDEPENDENT REVIEW DECISION

May 16, 2002

Requestor Respondent

RE: Injured Worker:
MDR Tracking #: M2-02-0613-01
IRO Certificate #: 4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ____ physician reviewer who is board certified in hand surgery which is the same specialty as the treating physician. The ____ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ____ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 36 year old female injured her wrist when she lifted a car battery on ___. X-rays performed on 10/17/01 revealed no fracture and mild soft tissue prominence at the right wrist. An EMG of the right wrist performed on 11/16/01 indicated that the upper extremity muscle study was essentially normal with no evidence of median or ulnar compression neuropathies, radiculopathy or plexopathy. A MRI performed on 12/04/01 indicated a slight increased signal involving the TFC complex specifically the meniscal homolog and a small amount of fluid in the radial ulnar joint. The patient was treated with anti-inflammatory medications and physical therapy.

Requested Service(s)

Dequervain's carpal tunnel release and wrist arthroscopy with TFCC debridement.

Decision

The dequervain's carpal tunnel release and wrist arthroscopy with TFCC debridement is not medically appropriate.

Rationale/Basis for Decision

The patient was initially diagnosed with wrist/forearm sprain/strain, which later improved with conservative treatment. The MRI failed to show any problem with the first dorsal compartment (dequervain's) and subsequently the patient began to show signs and symptoms in the adjacent areas. The patient had no initial complaints of paresthesias to support a diagnosis of carpal tunnel syndrome and had two essentially normal EMG/NCV studies. There is insufficient documentation to indicate that a trial of CTS injections were performed or what provocative tests were positive.

Conservative treatment in the form of injections and splinting should be performed before surgery is considered. Surgery is not an appropriate treatment at this time.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing. A request for hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code '148.3). This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code '102.4(h) or 102.5(d)). A request for hearing, along with a copy of this decision notice, should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, Texas 78704-0012.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

Sincerely,

cc: David Martinez, Chief Medical Dispute Resolution, Medical Review Division, TWCC

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this _____day of _____2002.

Signature of IRO Employee:

Printed Name of IRO Employee: